

## § 425.112

## 42 CFR Ch. IV (10–1–13 Edition)

to share in savings for that performance year.

### § 425.112 Required processes and patient-centeredness criteria.

(a) *General.* (1) An ACO must—

(i) Promote evidence-based medicine and beneficiary engagement, internally report on quality and cost metrics, and coordinate care;

(ii) Adopt a focus on patient centeredness that is promoted by the governing body and integrated into practice by leadership and management working with the organization's health care teams; and

(iii) Have defined processes to fulfill these requirements.

(2) An ACO must have a qualified healthcare professional responsible for the ACO's quality assurance and improvement program, which must include the defined processes included in paragraphs (b)(1) through (4) of this section.

(3) For each process specified in paragraphs (b)(1) through (4) of this section, the ACO must—

(i) Explain how it will require ACO participants and ACO providers/suppliers to comply with and implement each process (and subelement thereof), including the remedial processes and penalties (including the potential for expulsion) applicable to ACO participants and ACO providers/suppliers for failure to comply with and implement the required process; and

(ii) Explain how it will employ its internal assessments of cost and quality of care to improve continuously the ACO's care practices.

(b) *Required processes.* The ACO must define, establish, implement, evaluate, and periodically update processes to accomplish the following:

(1) Promote evidence-based medicine. These processes must cover diagnoses with significant potential for the ACO to achieve quality improvements taking into account the circumstances of individual beneficiaries.

(2) Promote patient engagement. These processes must address the following areas:

(i) Compliance with patient experience of care survey requirements in § 425.500.

(ii) Compliance with beneficiary representative requirements in § 425.106.

(iii) A process for evaluating the health needs of the ACO's population, including consideration of diversity in its patient populations, and a plan to address the needs of its population.

(A) In its plan to address the needs of its population, the ACO must describe how it intends to partner with community stakeholders to improve the health of its population.

(B) An ACO that has a stakeholder organization serving on its governing body will be deemed to have satisfied the requirement to partner with community stakeholders.

(iv) Communication of clinical knowledge/evidence-based medicine to beneficiaries in a way that is understandable to them.

(v) Beneficiary engagement and shared decision-making that takes into account the beneficiaries' unique needs, preferences, values, and priorities;

(vi) Written standards in place for beneficiary access and communication, and a process in place for beneficiaries to access their medical record.

(3) Develop an infrastructure for its ACO participants and ACO providers/suppliers to internally report on quality and cost metrics that enables the ACO to monitor, provide feedback, and evaluate its ACO participants and ACO provider(s)/supplier(s) performance and to use these results to improve care over time.

(4) Coordinate care across and among primary care physicians, specialists, and acute and post-acute providers and suppliers. The ACO must—

(i) Define its methods and processes established to coordinate care throughout an episode of care and during its transitions, such as discharge from a hospital or transfer of care from a primary care physician to a specialist (both inside and outside the ACO); and

(ii) As part of its application, the ACO must:

(A) Submit a description of its individualized care program, along with a sample individual care plan, and explain how this program is used to promote improved outcomes for, at a minimum, its high-risk and multiple chronic condition patients.

(B) Describe additional target populations that would benefit from individualized care plans. Individual care plans must take into account the community resources available to the individual.

**§ 425.114 Participation in other shared savings initiatives.**

(a) ACOs may not participate in the Shared Savings Program if they include an ACO participant that participates in the independence at home medical practice pilot program under section 1866E of the Act, a model tested or expanded under section 1115A of the Act that involves shared savings, or any other Medicare initiative that involves shared savings.

(b) CMS will review and deny an ACO's application if any ACO participants are participating in another Medicare initiative that involves shared savings payments.

(c) CMS will determine an appropriate method to ensure no duplication in payments for beneficiaries assigned to other shared savings programs or initiatives, including initiatives involving dually eligible beneficiaries, when such other shared savings programs have an assignment methodology that is different from the Shared Savings Program.

**Subpart C—Application Procedures and Participation Agreement**

**§ 425.200 Agreement with CMS.**

(a) *General.* In order to participate in the Shared Savings Program, an ACO must enter into a participation agreement with CMS for a period of not less than three years.

(b) *Term of agreement.* (1) *For 2012.* For applications that are approved to participate in the Shared Savings Program for 2012, the start date for the agreement will be one of the following:

(i) April 1, 2012 (term of the agreement is 3 years and 9 months).

(ii) July 1, 2012 (term of the agreement is 3 years and 6 months).

(2) For 2013 and all subsequent years—

(i) The start date is January 1 of that year; and

(ii) The term of the agreement is 3 years.

(c) *Performance year.* (1) Except as specified in paragraphs (b)(1)(i) and (ii) of this section, the ACO's performance year under the agreement is the 12 month period beginning on January 1 of each year during the term of the agreement unless otherwise noted in its agreement.

(2) For an ACO with a start date of April 1, 2012 or July 1, 2012, the ACO's first performance year is defined as 21 months or 18 months, respectively.

(d) During each calendar year of the agreement period, including the partial year associated with start dates specified in paragraph (b)(1)(i) and (ii) of this section, ACOs must submit measures in the form and manner required by CMS.

**§ 425.202 Application procedures.**

(a) *General rules.* (1) In order to obtain a determination regarding whether it meets the requirements to participate in the Shared Savings Program, a prospective ACO must submit a complete application in the form and manner required by CMS by the deadline established by CMS.

(2) An ACO executive who has the authority to legally bind the ACO must certify to the best of his or her knowledge, information, and belief that the information contained in the application is accurate, complete, and truthful.

(3) An ACO that seeks to participate in the Shared Savings Program and was newly formed after March 23, 2010, as defined in the Antitrust Policy Statement, must agree that CMS can share a copy of their application with the Antitrust Agencies.

(b) *Condensed application form.* PGP demonstration sites applying to participate in the Shared Savings Program will have an opportunity to complete a condensed application form.

(c) *Application review.* (1) CMS determines whether an applicant satisfies the requirements of this part and is qualified to participate in the Shared Savings Program.

(2) CMS approves or denies applications accordingly.